CLAIM FORM
COMMONWEALTH OF KENTUCKY
BOARD OF CLAIMS

130 Brighton Park Blvd.
Frankfort, Kentucky 40601
502-573-7986 **Fax (502) 573-4817** **800-469-2120**

Through KRS 44.070, the Board of Claims is vested with authority to compensate persons for damages sustained to person or property as a result of negligence on the part of the Commonwealth. The burden of proof that the Commonwealth was negligent rests with you. Please provide all facts, statements by witnesses (in writing), or any other proof you have that you believe would be helpful in the determination of your claim.

COMPLETE THIS FORM IN INK OR TYPE **COMPLETE ALL SECTIONS**

I._____
Claimant's Name Address

II._____
Name of State Agency involved with the incident (employee's name, if known)

III._____
Date and Time Incident Occurred (must be filed within one year)

IV._____** County_____
Where the Incident Occurred. Give **exact** location including **direction**, **milemarker**, **name** or **number of road**, **intersection**, etc. **PLEASE BE SPECIFIC**.

V. Describe the incident and the damage done to you or your property: _____

_____

_____

_____

_____

_____

_____

_____

VI. In what way do you believe the state agency or employee was at fault? _____

_____

_____

VII. State the specific dollar amount of your claim. Supply bills, receipts and/or **TWO** repair estimates as proof of the cost of damages sustained. **This amount will be amended according to the amount you can recover from insurance**.

$_____

VIII. If motor vehicles were involved, please complete the following:

STATE VEHICLE:

Tag number, if known _____

Driver, if known _____

Does the operator of the state vehicle have a rider on his insurance policy to cover him/her while operating a state vehicle? _____

If the state employee does have a rider, the claimant must go through the state employee's insurance.

CLAIMANT'S VEHICLE:

In whose name is the vehicle registered? _____

** **This claim must be filed and signed by the registered owner.**

Vehicle year, make and model: _____

Name and address of driver and passengers:

_____

_____

Name of law enforcement authority or officer who investigated the incident:

_____

Please submit a copy of police report, incident report, or Uniform Traffic Report if possible.

YOU MUST SIGN : Claimant's Signature:_____

Attorney's Information: Attorney's Signature:_____
(*if represented by Counsel*)

_____ Address: _____
(print name)

_____ _____
(address)

_____ _____

_____ Telephone: (home) _____(work)_____

Phone: _____ Date: _____

WE MUST HAVE: Social Security Number or Federal ID Number: _____

Claim must be presented to the Board of Claims within one year from the date of the incident.
IF CLAIMANT IS A CORPORATION THEN CLAIM MUST BE FILED BY AN ATTORNEY LICENSED IN THE STATE OF KENTUCKY.

THIS PAGE MUST BE COMPLETED

Pursuant to KRS 44.070 (1) the Board of Claims is required to reduce damage claims by the amount the claimant can recover through his/her insurance. In order to process your claim as submitted, provide all information below that relates to the damages you incurred (car damage #1 thru #5, personal injury #6, #7, and #9, home damage #8 and #9).

1) Insurance Agent and Address: _____

_____

_____

telephone # _____

2) Insurance Company: _____
Policy Number: _____
Effective Dates: _____

3) Collision Coverage in Effect: ( )Yes ( )No Amount of Deductible $ _____

4) Comprehensive Coverage in Effect: ( )Yes ( )No Amount of Deductible $ _____

5) Liability only: ( )Yes ( )No

6) Hospitalization Insurance in Effect: ( )Yes ( ) No

Pursuant to KRS 44.070, the Board can only pay what claimant cannot recover through insurance. Please show proof that all bills have been submitted to your insurance company and provide exact amount of claimant's out-of-pocket expenses and amount covered by insurance.

Name of Insurance Company: _____
Policy Number: _____Effective Dates: _____
Amount of Deductible: _____Has your deductible been met this year?( )Yes ( )No

7) Compensation Insurance Coverage in Effect: ( )Yes ( )No
Name of Company: _____
Policy Number: _____Effective Dates: _____
Deductible: _____ Been Met? ( )Yes ( )No

8) Homeowner _____Dwelling _____or Mobile Home Coverage _____

Name of Company: _____
Policy Number: _____ Effective Dates: _____
Deductible: _____ Been Met? ( )Yes ( )No

9) If you have any other insurance coverage that would entitle you to recover the damages which are the subject of your claim, please list what type and the amount of the deductible, if any.

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